STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. BUILDING _____ B. WING _____	C 08/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #77241.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility identified a census of 186 residents	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1	F 157		

with 38 residents residing on the Eastminister unit. The sample included 3 residents reviewed for medication administration. Based on observation, interview, and record review, the facility failed to notify the legal representative of one resident (#1) after a medication administration error.

Findings included:

- According to the clinical face sheet, the facility admitted resident #1 on 11/27/2013

Review of the Physician's Order Sheet dated 5/1/14 recorded diagnoses that included congestive heart failure (a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (elevated blood pressure), and hypoxia (inadequate supply of oxygen).

Review of the significant change Minimum Data Set (MDS) 3.0 Assessment dated 6/22/14 recorded the resident with a Brief Interview for Mental Status (BIMS) total score of 15, which indicated intact cognition. The resident was totally dependent on staff for activities of daily living (ADLs) except required extensive assistance from staff for eating.

Review of the Care Area Assessment (CAAs) dated 6/25/14 for falls recorded the resident received medications for high blood pressure that included Norvasc 5 milligram every morning, Catapress 0.2 milligrams twice daily, Lasix 40 milligrams every morning, Lisinopril 20 milligrams every morning, Metoprolol 6.25 milligrams twice

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F 157	Continued From page 2	F 157		

daily and Tekurna 300 milligrams every morning. The CAA dated 6/25/14 for psychotropic medications documented the resident with a long history of congestive heart failure, hypertension, and atrial fibrillation (rapid, irregular heartbeat).

Review of the resident's plan of care dated 6/22/14 directed staff to monitor the resident for shortness of breath, monitor medications for potential side effects and pharmacist reviewed monthly for recommendations or suggestions of dose reductions to the resident's physician as appropriate.

Nursing note dated 7/10/14 timed 9:54 P.M. recorded the resident received Metoprolol tartrate (used for high blood pressure) 50 milligrams at 6:00 P.M. Nursing staff notified the physician and received orders to take the resident's blood pressure every hour and report back to the physician at 11:00 P.M.

Review of the resident's medication administration record for July 2014 lacked a physician order for Metoprolol tartrate 50 milligrams.

Review of the resident's clinical record lacked evidence the facility staff notified the resident or the family of the medication error.

Nursing note dated 7/11/14 timed 1:04 P.M., documented the resident with a decreased level of consciousness, unresponsive to verbal or tactile stimuli, and blood pressure 68/39. Staff notified the physician at 12:33 P.M. and received an order to send the resident to the hospital emergency room.

Review of the facility reported investigation dated

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F 157	Continued From page 3 7/18/14 documented, during medication administration a licensed staff administered the resident another resident's medication. The facility investigation documented the physician admitted the resident to the hospital for shock-related to a beta blocker (metoprolol), possible sepsis (a systemic infection) and aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit). This same investigation recorded the resident returned to the facility on 7/15/14 at approximately 3:00 P.M. to continue with hospice care and services. On 8/8/14 at 2:50 P.M. licensed nursing staff J stated when a medication error occurred, nursing staff notified the director of nursing, the physician for instructions and notified the resident's responsible party of the error. On 8/8/14 at 3:15 P.M., licensed nursing staff K reported following a medication error nursing staff called the physician, administrative facility staff, and notified the resident's responsible party. On 8/8/14 at 3:20 P.M. administrative nursing staff D revealed staff notified the administrative staff, physician, and the resident's responsible party of an incident with a medication error. Administrative nursing staff D reported nursing staff failed to notify the resident's responsible party on 7/11/14 after the medication error. On 8/8/14 at 3:35 P.M. licensed nursing staff I revealed when a medication error occurred, staff notified the physician, administrative facility staff, and the resident's family or responsible party. On 8/8/14 at 4:00 P.M. licensed nursing staff H reported he/she did not notify the resident's	F 157		

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F 157	Continued From page 4 responsible party about the medication error. On 8/13/14 at 1:00 P.M. administrative nursing staff D reported nursing staff documented family notification in the nursing notes. The nursing staff did not notify the resident's family until just prior to the resident going to the hospital the next day. Review of the facility provided policy Incident Reporting dated 11/19/13 documented staff documented each incident involving a resident/patient in the medical record at the time it occurred or was discovered. Documentation included a factual description of the incident, nursing interventions, and name (and time) of physician and family notification. Staff documented the date and time the resident's family was notified, and by whom. The facility failed to notify this resident legal representative following an incident involving the resident receiving the wrong medication, which required physician intervention.	F 157		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This Requirement is not met as evidenced by: The facility identified a census of 186 residents with 38 residents residing on the Eastminister unit. The sample included 3 residents reviewed for medication administration. Based on observation, interview, and record review, the facility failed to administer medication as physician ordered for 1 (#1) resident of the sample.	F 333		

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F 333	Continued From page 5 Findings included: - According to the clinical face sheet, the facility admitted resident #1 on 11/27/2013 Review of the Physician's Order Sheet dated 5/1/14 recorded diagnoses that included congestive heart failure (a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (elevated blood pressure, and hypoxia (inadequate supply of oxygen). Review of the significant change Minimum Data Set (MDS) 3.0 Assessment dated 6/22/14 recorded the resident with a Brief Interview for Mental Status (BIMS) total score of 15, which indicated intact cognition. The resident was totally dependent on staff for activities of daily living (ADLs) except required extensive assistance from staff for eating. Review of the Care Area Assessment (CAAs) dated 6/25/14 for falls recorded the resident received medications for high blood pressure that included Norvasc 5 milligram every morning, Catapress 0.2 milligrams twice daily, Lasix 40 milligrams every morning, Lisinopril 20 milligrams every morning, Metoprolol 6.25 milligrams twice daily and Tekurna 300 milligrams every morning. The CAA dated 6/25/14 for psychotropic medications documented the resident with a long history of congestive heart failure, hypertension, and atrial fibrillation (rapid, irregular heartbeat). Review of the resident's plan of care dated 6/22/14 directed staff to monitor the resident for	F 333		

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F 333	Continued From page 6	F 333		

shortness of breath, monitor medications for potential side effects and pharmacist reviewed monthly for recommendations or suggestions of dose reductions to the resident's physician as appropriate.

Nursing note dated 7/10/14 timed 9:54 P.M. recorded the resident received Metoprolol tartrate (used for high blood pressure) 50 milligrams at 6:00 P.M. Nursing staff notified the physician and received orders to take the resident's blood pressure every hour and report back to the physician at 11:00 P.M.

Review of the resident's medication administration record for July 2014 lacked a physician order for Metoprolol tartrate 50 milligrams.

Nursing note dated 7/11/14 timed 1:04 P.M., documented the resident with a decreased level of consciousness, unresponsive to verbal or tactile stimuli, and blood pressure 68/39. Staff notified the physician at 12:33 P.M. and received an order to send the resident to the hospital emergency room.

Review of the facility reported investigation dated 7/18/14 documented during medication administration a licensed staff administered the resident another resident's medication. The facility investigation documented the physician admitted the resident to the hospital for shock-related to a beta blocker (metoprolol), possible sepsis (a systemic infection) and aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit). This same investigation recorded the resident returned to the facility on 7/15/14 at approximately 3:00 P.M. to continue with hospice

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F 333	Continued From page 7 care and services. On 8/8/14 at 2:50 P.M. licensed nursing staff J stated before administering medication the nursing staff identify the resident with their photo in the computer, photo on the wall room entrance, and then asked the resident their name. Licensed nursing staff J reported the resident do not wear identification bracelets. On 8/8/14 at 3:15 P.M., licensed nursing staff K reported a liberalized medication administration times for the evening medication between 4:00 P.M. and 6:00 P.M. Licensed nursing staff K revealed during medication pass staff identified the resident's photo on the electronic medication administration record (EMAR), resident's photo on the door nametag, and asked the resident their name. On 8/8/14 at 3:20 P.M. administrative nursing staff D revealed the resident received a different resident's medication, the nurse realized it immediately, and called the facility administrative staff and the resident's physician. Administrative nursing staff D reported nursing staff obtained a physician order and then sent the resident to the hospital emergency room for treatment of low blood pressure. On 8/8/14 at 3:35 P.M. licensed nursing staff I revealed before staff gave medications to a resident, they asked the resident's name, and look at the residents photo on the EMAR and at their room door. On 8/8/14 at 4:00 P.M. licensed nursing staff H reported he/she did not know how the medication error occurred and reported giving the resident another resident's blood pressure medication in	F 333		

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F 333	Continued From page 8 the dining room. Nursing staff verified the correct resident by the photo on the EMAR, photo on the room door, and direct knowledge of knowing that resident. Now staff can only administer a resident's medications in their own room. On 8/13/14 at 1:00 P.M., consultant pharmacist HH reported the pharmacy had performed medication pass observations and questioned staff about the main reasons for medication errors, which were interruptions and being in a hurry. The pharmacy consulting staff helped to intermittently train staff and reminded them to keep focused on what they were currently doing with medication administration. Review of the facility provided undated policy Medication Administration documented prior to administration, the medication and dosage schedule on the resident's MAR was compared with the mediation label. Medications were administered in accordance with written orders of the attending physician. Medications were administered at the time they were prepared. The person who prepared the dose for administration was the person who administered the dose. The staff identified the resident before medication was administered. Methods of identification included: 1) Checking photograph attached to medical record, 2) calling resident by name, and 3) and if necessary, verifying the resident identification with other facility personnel. The staff who administered the medication dose recorded the administration on the resident's MAR directly after the medication was given. The facility administered an antihypertensive medication without a physician's order. The resident experienced low blood pressure and required hospitalization.	F 333		